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ABSTRACT

About 1 in 12 couples in the United States face the "how to have" element of reproductive choices. Assistive Reproductive Technology (ART) involves manipulation of genetic material outside of the body. Infertile couples have a large range of options in the achievement of a conception and are easily overwhelmed. As new choices are offered to couples, societal apprehension and confusion increase. Psychologists can find themselves in many different roles with couples who are engaged in the infertility experience. Educator, facilitator, evaluator, counselor and therapist are all possibilities with the couple using ART or third-party reproduction. As educator the psychologist assists with normalizing the concomitant emotions and stresses of infertility and the treatment procedures themselves. As facilitator the psychologist assesses the support resources available to the couple and assists in the decision making process. As evaluator the psychologist may do a psychological evaluation. Assessment of patients' pretreatment anxiety and depression can assist in the development of an appropriate treatment strategy. The counselor role overlaps all previously described roles--from strengthening the couple's relationship to preparing them for unsuccessful outcomes. The psychologists' role as therapist will address the interpersonal and intrapersonal dynamics that have been evoked or highlighted by the infertility trauma. (JBJ)

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The Psychologist's Role in Family Building With Reproductive Technology

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The Psychologist's Role In Family Building

Through Reproductive Technology

Louis Brown was born in England in 1978. The remarkableness of her birth was her conception in a petri dish. She is the first child born with the aid of the reproductive technology known as In Vitro Fertilization (IVF). Now seventeen years later IVF is only one of the many alphabet soup options an infertile couple has in pursuing their choice to build a family. Some five years after Louis's birth, Warren Miller(1983) wrote in an American Psychologist article about the increasing trend toward choice in human reproduction. His capacity for prediction is evident in this quote.

> Whatever unfolds, it can almost certainly be said that the coming decades will see vast, perhaps logarithmic, increases in the human capacity to regulate all aspects of reproduction, including not only whether to have children, how many to have, and when to have them, but also how to have them and what kind of children to have (Miller, 1983, p. 1203).

About one in twelve couples in the United States face the " how to have" element of reproductive choice. These approximately 2.3 million couples are consider infertile. (Mosher & Pratt, 1990). Within five years only about 20% of these couples will still be unable to conceive a child, even with medical intervention. The couples who have succeeded will range from those who needed better education on the timing of intercourse to those that spend their life savings on a conception that occurs in a lab. Some will need medication to regulate ovulation. Others will have corrective surgeries for anatomical abnormalities. 5% of the successful group will become pregnant spontaneously. Some of the couples will have had to answer the question "what kind of child" when they chose to utilize donor gametes to have that conception. Many will have tried some form of Assisted Reproductive Technology (ART) either because it was the most appropriate treatment for their problem or because it was the last procedure to try. For those left still trying

after five years and those in the older age groups, ART may be the only possible option.

Let me review briefly the treatment options and adjunct therapies that generally fall under the category of Assisted Reproductive Technology(ART). All involve manipulation of genetic material outside of the body. In vitro fertilization (IVF) involves extracting eggs from the woman's hyperstimulated ovaries; fertilizing them with her partner's prepared sperm in the lab; incubating them until division has started and than transferring embryos back to the uterus for implantation. Gamete intrafollopian transfer (GIFT) involves less time for the gametes to be outside the body. Extracted eggs are placed directly into the fallopian tubes surgically, followed directly by prepared sperm for fertilization inside the tube. Zygote intrafallopian transfer (ZIFT) or tubal embryo transfer (TET) involves transferring the embryos to the fallopian tubes instead of the uterus. More recently laboratory procedures have been developed to make the eggs more receptive to sperm penetration (assisted hatching) and to actually place a sperm into the egg for fertilization, intracytoplasmic sperm injection (ICSI). Sperm are now being aspirated from the testicles of some men and utilized for ICSI. The adjunctive processes that might require the couple's decision making skills include embryo cryopreservation, the utilization of donor gametes and gestational surrogacy.

As is evident in this listing the couple who believes that choice plays a significant role in the achievement of a conception easily can be overwhelmed when confronted with infertility. The couple who can leave conception to chance might move directly to living with the fate of being without a child or looking for a way to adopt a child that appears to "need a home".

Miller (1983) suggests that society has to accept massive changes in shared values and beliefs in order for these technologies to take hold. As these new choices are offered up to couples societal apprehension and confusion increase. "Existing values and beliefs are insufficiently clear to guide decision making and to reinforce the taking of responsibility that is associated with it" (Miller, 1983, p. 1203). Van Hall (1988) suggests that everyone has something to say about reproduction which is why its manipulation is

such a volatile topic. The postgraduate training of the Mental Health Professional Group of the American Society for Reproductive Medicine has attempted to raise awareness and give guidance where possible about the dilemma psychologists and other mental health professionals have when they enter into the decision making process with couples.

Psychologists can find themselves in many different roles with couples who are engaged in the infertility experience. Educator, facilitator, evaluator, counselor and therapist are all possibilities with the couple utilizing ART or third-party reproduction. The private practitioner as well as the psychologist team member can find him/herself in these roles.

Psychologist as Educator

The function of education is a significant one for the psychologist working with the new reproductive technologies. Normalizing the concomitant emotions and the stresses of infertility and the treatment procedures themselves are part of patient education for all infertile couples. In particular for ART couples, financial cost and low probability of success are additional stressors. Determining that ART couples have sufficient understanding of the complex possibilities in a single treatment cycle before giving consent frequently falls to the psychologist if one is available to the program. This can includes identifying and clarifying issues such as cryopreservation, multiple pregnancies, selective reduction, utilization of donor gametes or gestational carrier. The private practitioner who has experience with infertility can educate. One without infertility experience can help the couple formulate the necessary questions to ask to be fully informed.

The educator role can extend to the treatment team. The patient-doctor relationship can be enhanced by providing pretreatment information to the couple, providing them with the opportunity to feel like a team member. Patient satisfaction can increase independent of outcome because preparation provides them with

more of a sense of control (Covington, 1994). This is very important because all ART treatments fall at a 50% or lower probability of success.

Psychologist as Facilitator

The facilitator function is important in assessing the support resources available to the couple and assisting the decision making process. In an attempt to protect themselves from intrusive questions about reproduction, infertile couples may respond with rigid boundaries between themselves and their families of origin and their friends. This protection can lead to a sense of isolation (Mikesell & Stohner, 1995). This isolation can lead to a lack of social supports.

Identification and utilization of social supports is linked to the management of infertility stress (Abbey, Andrews, & Halman, 1991). Facilitating the transition from isolation to selective openness is essential for adequate healing. Although the relationship still may be available for support in the early stages of infertility, by the time couples are faced with the decision to pursue an ART cycle they likely have depleted this resource. Family and friends that have been supportive should be approached first. A necessary prerequisite is educating the selected individual about the couple's unique needs for infertility support at this time. This may mean asking them to wait until the couple contacts them about the treatment plan and its outcome.

Group support through the medical practice or through the community, such as Resolve, can lower the sense of isolation and increase coping skills and problem solving. Specific classes on the relaxation response and meditation can provide tools for self management.

The educative and facilitative functions overlap in the process of decision making. Couples not only need to make a decision about which ART treatment they are going to pursue but also be prepared to handle the many changes that are possible in a given cycle that will alter their previous medical decisions. They need

to know how a cycle could be disrupted or prematurely terminated.

The psychologist can facilitate the sorting through of any religious and ethical concerns that may be raised by the treatment options being considered. Ignoring differences between the members of the couple in this area invites the potential for future marital and family distress.

In the ART process hyperovualtion is desired. A limited number of embryos are returned to the uterus regardless of the number of eggs that are fertilized in order to limit the likelihood of a multiple pregnancy. This has to be balance with the number of embryos that need to be transferred to provide the highest probability of success. How the couple wants to handle any remaining embryos needs to be decided prior to the procedure.. This may mean cryopreservation, sharing their embryos with another couple or discarding the unused ones. The other decision to be considered is the risk and management of a multifetal pregnancy. The particular question that needs exploration involves the use of multifetal selective reduction.

An additional decision that may need to be made during ART cycles involving male infertility is the utilization of donor sperm. This option is likely to come up if there is concern about fertilization with the partner's sperm. Couples need to know if this is a recommendation or a back up option. The couple needs time for the ramifications of the use of donor sperm to sink in. It is not fair for the couple to put themselves in the position to either scrap a cycle or choose donor on the spot. Choosing ART invites couples to a new level of decision making.

Psychologist as Evaluator

One of the more traditional roles a psychologist can have in working with ART couples is to do a psychological evaluation. This can be more or less formal. An assessment of patients pretreatment anxiety and depression as well as their history of these disorders can provide the team and the patients with information for the development of a treatment strategy that will more directly address the negative

emotional responses to an ART cycle (Newton, Hearn, & Yuzpe, 1990). Readiness may also be assessed by exploring the strategies the couple has used to begin the healing process from previous disappointing treatment outcomes. These type of evaluations are most easily facilitated when a program has a psychologist as part of the ART team (Greenfeld, Mazure, & Haseltine, 1983).

Couples who are utilizing donor gametes are frequently evaluated prior to treatment. This may involve personality assessments and marital relationship evaluations or simply a clinical interview. Again the psychologist may be asked to evaluate the ability of the couple to give informed consent or to determine there thinking through of the consequences of this choice. The evaluator can be placed in the role of gatekeeper by being asked to assess their parenting ability. No assessment tools can adequately assess parenting. The psychologist is better equipped to evaluate the likelihood of the couple managing either the unusual circumstances of berthing a donor child or failing at the final treatment option.

Psychologists are also involved in the assessment of individual gamete donors. Ovum donor programs require a clean psychological evaluation to utilize a given donor. This is less often required by sperm banks. Gestational carriers, sibling donors and surrogates are also evaluated for emotional stability.

Psychologist as Counselor

This role overlaps all the previously described roles. Strengthening the couple relationship, grieving the loss of the "wished for" child, integrating the involvement of a third party, preparing for unsuccessful outcomes, terminating medical pursuits, and pursuing alternate family building options are all possible counseling concerns. The psychologist may only have a one session opportunity to identify and address these needs depending on the setting in which the psychologist has contact with the infertile couple. So an additional counseling responsibility is to identify resources that the couple can use to complete any work identified.

Psychologist as Therapist

This role differs from that of counselor in that the therapist addresses the interpersonal and intrapersonal dynamics that have been evoked or highlighted by the infertility trauma. The infertility might be the necessary experience to bring the couple or individual to the place where the long standing problem can no longer be dismissed or avoided. It is important that the therapist value this life event trauma and help the persons integrate it into their sense of self.

The psychologist who is privledged to work with couples and individuals who are pursuing a family within this technological explosion takes on a burdensome responsibility. One has to be able to move readily from one role to another and be constantly aware of the limits that come with the lack of ethical, legal and psychological research supports for the responses requested in these roles. Helping couples find their path to their generative development can only hold more and interesting opportunities as science, psychology, and society grow and change in their pursuit of human reproduction.

References

Abbey, A. Andrews, F. M. & Halman, L. J. (1991). The importance of social relationships for infertile couples' well-being. In A.L. Stanton & C. Dunkel-Schetter (Eds.), Perspectives from stress and coping research (61-68). New York: Plenum.

Covington, S. N. (1994). Preparing the patient for in vitro fertilization: Psychological consideerations. ClinicaLConsultations in Obstertics and Gynecology, 6(2), 131-137.

Greenfeld, D., Mazure, C. & Haseltine, F. P. (1983). The role of the social worker in the in vitro fertilization program. Social Work Health Care,10, 71-79.

Mikesell, S.G. & Stohner, M. (1995). Infertility and pregnancy loss: The role of the familyconsultant. In R. H. Mikesell, D-D Lusterman & S. H. McDaniel (Eds.), Integrating family therapy: Handbook of family psychology and systems theory (pp.421-436). Washington, DC: American Psychological Association.

Miller, W. B. (1983). Chance, choice,and the future of reproduction. American Psychologist, 1198-1205.

Mosher, W. D. & Pratt, W.F. (1990). Fecundity & infertility inthe United States 1965-1988: Advance data-192. Washington, DC: National Center for Health Statistics.

Newton, C. R., Hearn, M. T. & Yuzpe, A. A. (1990). Psychological assessment and follow-up after in vitro fertilization: Assessing the impact of failure. Fertility and sterility,54. 879-886.

van Hall, E. V. (1988). Manipulation of human reproduction. Journal of psychosomatic obstetrics and gynecology, 9, 207-213.